Simponi (Golimumab) Prior Authorization Request Form

5601

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Pharmacy Program (TPharm). Express Scripts is the TPHARM contractor for DoD.

SPECIAL NOTES: Simponi, Cimzia, Enbrel, and Kineret are non-formulary (Tier 3) under the DoD Uniform Formulary and carry a higher copay for non-Active duty beneficiaries than Humira and Amevive, which are formulary (Tier 2). TRICARE does not cover Simponi for Active duty beneficiaries, who pay no co-pay, unless it is determined to be medically necessary instead of a formulary agent.

Medical necessity forms are available on the TRICARE Pharmacy website at http://pec.ha.osd.mil/forms_criteria.php.. This form may NOT be used to meet medical necessity requirements. Active duty beneficiaries newly starting on Cimzia, Enbrel, Kineret, or Simponi require both forms.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at https://rxnet.army.mil/pec/forms_criteria.php. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: **Simponi (golimumab)**

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID# _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment**

1. Will the patient be receiving Orencia (abatacept), Humira (adalimumab), Kineret (anakinra), Cimzia (certolizumab), Enbrel (etanercept), Remicade (infliximab), or Rituxan (rituximab) in combination with Simponi?	☐ Yes **Coverage not approved**	☐ No **Please proceed to Question 2**
2. Is Simponi being prescribed for moderate to severely active rheumatoid arthritis?	☐ Yes **Please proceed to Question 3**	☐ No **Please proceed to question 4**
3. Does the patient already have an active prescription for methotrexate?	☐ Yes **Please sign and date. See quantity limits below**	☐ No **Coverage not approved**
4. Is Simponi being prescribed for the treatment of moderate to severely active psoriatic arthritis or the treatment of active ankylosing spondylitis?	☐ Yes **Please sign and date. See quantity limits below**	☐ No **Coverage not approved**

Quantity limits: limited to a 4-week supply in retail and an 8-week supply in mail order

Step 3 **I certify that the above is correct to the best of my knowledge** (Please sign and date):

_____ _____

Prescriber Signature Date